PRINTED: 06/24/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1934	A. BUILDING _____ B. WING _____	C 06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCKENDREE VILLAGE INC	4347 LEBANON ROAD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments Complaint investigation #28120 was completed at McKendree Village on June 22, 2011. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	N 000 No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Fred R. Levoy, Administrator — (X6) DATE: 7-7-2011

STATE FORM 6899 HJZ911 If continuation sheet 1 of 1

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